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SMMGP

Substance Misuse Management in General Practice Newsletter

The New Department of Health Clinical Guidelines for Drug Misuse and Dependence : why are they important?

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The new Department of Health Clinical Guidelines for Drug Misuse and Dependence (1), published in April this year, replaced the old 1991 Guidelines and have been endorsed by all four health departments in the United Kingdom. They were produced by a multi-disciplinary committee in an attempt to be evidenced based, relying on the work of the Task Force 1996(2) and are fully referenced. They were published by the Department of Health within the framework of their good practice booklet on Clinical Guidelines (3) and they are firmly based in government policy. They have seven main chapters, which will be discussed briefly in this report, and 18 practical and useful annexes.

Overview

So how do the new guidelines differ from the 1991 version? The old guidelines were very much in the style of traditional clinical guidelines in that they emphasised an individual approach regarding specific clinical management issues. They gave no overview of service provision and no specific view of shared care, and they made a number of assumptions about the availability of services, which were not always borne out in practice. The new guidelines on the other hand are part vision statements, part policy statement and part textbook. They do include the specific "clinical" guidelines, but they place a major emphasis on the mechanics of service provision and shared care. They also rely heavily on the evidenced base regarding methadone maintenance treatment which is now available. These changes reflect the changes in the field of drug misuse treatment this decade.

Context of Change

The guidelines are a product of their time and as such they reflect their context In particular they reflect service developments and changes in the pattern of drug misuse treatments. They also take account of the Task Force report in 1996(2) and the 10-year plan 1998(4) both of which emphasise the role of primary care in the treatment of drug misuse. However, they also demonstrate an awareness of the dangers of methadone and in this respect they echo the ground-swell of opinion against "maverick" treatment which has aroused much media interest and derives from the low public tolerance of methadone related deaths compared with heroin deaths. The guidelines also reflect the current emphasis on medical legal issues and the necessity for practice to be defensible. The tension evident in this context runs right through the guidelines: the right to treatment versus safe prescribing, and clinical freedom versus agreed protocols.

Overall Approach taken by the New Guidelines

The following four principles underlie the main thrust of the guidelines:

1. The use of evidence based interventions is recommended especially methadone maintenance.
2. There is a responsibility of the doctors at all levels to address drug related problems and prevention of harm.
3. The specifics of service provision are important for service delivery.
4. There is a central role for shared care in delivering services.

However the dualistic nature of the context within which we operate is reflected once again in the ambivalence of the guidelines towards shared care: primary care doctors are to treat drug misusers, but doctors are warned to keep within a broadly agreed protocol.

Chapter I – Key Points

This chapter is all about the rights and responsibilities of doctors and patients. The main general points are as follows:

- Drug users have the same NHS entitlement as other patients.
- All doctors should provide care for general health and drug related problems (including Hepatitis B vaccination and harm minimisation advice).

- On the other hand, no doctor should be put under pressure to provide treatment beyond a reasonably expected standard for the average practitioner in his or her position, and
- All GPs treating drug misusers have a right to support from the health authority or relevant primary care organisation.

This represents an important development in the recognition of the rights of GPs to get support for work with which they are unfamiliar.

- Emphasis on a harm minimisation approach because it is evidence based (5,6).

More specifically, the chapter divides doctors involved in the treatment of drug misuse into three levels:

1. The Generalist

- May be involved in treatment of drug misuse but this is not their area of main work.
- Should be competent to care for drug misusers on a shared care basis (includes assessment, substitute prescribing).
- Needs back up of shared care and regular training.

2.Specialised-Generalist

- Not primarily concerned with drug misuse but has a special interest.
- Could involve prescription of specialised drug regimes.
- Appropriate training required.

3. Specialist

- Drug misuse is the main clinical activity.
- Specialised prescribing/expert resource.
- Should hold high qualifications with specialist training.

My concerns with this classification are as follows:

1. it fails to emphasise the responsibility of doctors who are not involved directly in the treatment of drug users at any level, but who encounter them in their clinical practice.
2. the classification attempts to define what activities should be carried out at these different levels of involvement, without addressing the thorny issue of accreditation, which is hinted at in the guidelines but not explicitly addressed.

Chapter II Treatment – Key Points

This chapter attempts to define the structure of treatment delivery and how it should be monitored.

- Local shared care guidelines should be developed (primary care groups to be involved in this).
- Local level Shared Care Monitoring Groups should be set up, relating to drug action teams and involving the Director of Public Health and representation from all relevant agencies. These Shared Care Monitoring Groups would approve local agreement and protocols as well as reviewing training needs, clarifying performance indicators and monitoring the delivery and effectiveness of shared care.
- Underlying principles for treatment:
  1? Multi-disciplinary approach
  2? Importance of the structure of service provision- the health authority has the responsibility to provide services and support GPs, and explicit local shared care arrangements should be made.
  3? Patients requiring specialist services should still get their general medical services from a GP.
  4? Treatment should be based on harm minimisation because there is an evidence base for this (5,6).

Once again these principles broaden out the responsibility for drug misuse treatment but an emphasis is still placed on reducing diversion of prescribed drugs and the building in of safeguards.

Chapter III Assessment – Key Points

Once again this chapter seeks to broaden the responsibility for drug misuse treatment whilst building in suitable safeguards. It states that all members of the multi-disciplinary team should have assessment skills, but that only in exceptional circumstances should substitute medication be prescribed without specialist/generalist or specialist advice. However in those exceptional circumstances, there is a responsibility to treat. There is an emphasis on adequate assessment (history, examination, urinalysis etc) which must be made before prescribing substitute medication. However the role of urinalysis whilst frequently mentioned is never really clarified and whilst it is recorded as an adjunct to history and examination in confirming drug use, it is in no way suggested that the results of urinalysis should be used in order to determine whether or not the patient is allowed to remain in treatment.

Chapter IV Responsibilities of Prescriber – Key Points

This chapter is a key statement of principles within the guidelines: it states the rights of patients to be treated but also stresses the responsibilities of doctors to provide treatment safely.

- All doctors must care for general health and drug related problems, but
- Prescribing should only be done as part of a multi-disciplinary intervention, and
- Specialist help should be sought especially when using new drugs

The chapter outlines a number of safeguards for prescribers and patients which are in fact very specific:

- All new prescriptions to be taken initially under daily-supervised consumption for a minimum of three months (subject to social factors).
- Substitute drugs to be dispensed on a daily basis but less often when stable.
- The clinician has a responsibility to ensure that the patient receives the correct dose and that diversion is avoided.
- The doctor should liaise with the pharmacist about specific patients and regimes.
- *No more than one week's drugs should be dispensed together.
- Prescribing of injectable formulations (by specialists or after specialist assessment) has "a very limited place".
- Tablets should not be prescribed.

Chapter V Dependence and Withdrawal, VI Dose Reduction, and VII Preventing Relapse – Key Points

Chapter V and the next two chapters are about textbook aspects of treatment but once again safeguards and evidence based prescribing are emphasised. Major points are as follows:

- Safe dispensing and supervised consumption are emphasised throughout.
- Doctors should adhere to licensed medications where possible (NB Dihydrocodeine not licensed and not recommended).
- Non-prescription routes from addiction should be sought.
- Benzodiazepines have no evidence base for maintenance treatment. They are recommended and licensed only for management of withdrawal.
- Stimulants should be prescribed in specialist settings only and are not licensed.
- Methadone maintenance treatment is widely evaluated (and should occupy a key position (Task Force 1996)(2)

But once again the tension between clinical freedom and safety is evident.

- Information on recognition and management toxicity should be given to patients and carers.
- No injectable preparations are licensed for use in drug dependence but these are probably useful for some patients and should where possible be used on a daily dispensing regime – supervised where necessary.
- Diamorphine prescribing: "very little clinical indication".
- This last recommendation does in fact fly in the face of the evidence base which suggests that diamorphine prescribing under the right circumstances may be extremely useful (7).
- It is the responsibility of the prescriber to ensure that patients receive the correct dose and to avoid diversion.

This places a very strong responsibility on prescribers which is not normally in place with regard to other prescriptions.

- Take–home doses are not appropriate where:
  1? There is an unstable or increasing pattern of drug misuse (this is not clearly defined)
  2? Where there is unstable psychiatric illness
  3? Where there is concern regarding diversion of prescribed drugs (this is also very poorly defined)
- Important role for community pharmacist includes supervising consumption and taking part in shared care, with safeguards regarding confidentiality.

Strengths of the New Guidelines

Individual clinicians will inevitably not find themselves in agreement with every one of the guidelines. It is in the nature of national protocols that they are not perfect and need to be adapted for local use. Nevertheless these guidelines have a number of strengths. First they represent an attempt to recognise and formalise changes that have already taken place in the treatment of drug misusers, and to put this in a framework. They attempt to derive an evidence based practice from the often unrecognised and increasingly diverse evidence base. They emphasise a multi-disciplinary rather than a rigidly medical approach and they take a robust attitude to the responsibility of all doctors and the rights of all patients within the health service. There is also a new and important recognition that good practice cannot exist without good structures for service provision and that administrators as well as doctors hold a responsibility for this. Within these structures the guidelines are prepared to confront the realities of shared care and local differences in provision whilst maintaining an emphasis and the avoidance of diversion of prescribed drugs and the final responsibility of the prescriber.

On a very different note, the annexes are wide ranging and cover a number of practical problem areas in great detail, including equivalent doses of drugs, drugs and driving, drugs and pregnancy and other complex issues.

Weakness of the New Guidelines

The new guidelines were written by a committee and, at times, it shows. Whilst it apparent that there is a real attempt to be prescriptive, they nevertheless back off at the last minute in some areas. Whilst this allows room for clinical judgement and prevents the guidelines from being too prescriptive it nevertheless can result in weakness as in the failure to spell out the expected role of the non-prescribing GP with no interest in drug misuse in spite of the fact that failure to provide medical care on the part of some GPs can be one of the worst problems facing the drug user. There is also a lack of evidence base for some of the more specific recommendations, including the need for supervised consumption

and the role of take-home doses, and the role of diamorphine prescribing is not properly evaluated in the light of available evidence

Why are the Guidelines important?

In spite of any reservations about the new guidelines, they are nonetheless a reflection and also a definition of the framework from which we operate. Once again they reflect the tensions between the right to treatment and the necessity to be safe. There is no escaping the drive towards standardisation of practice and the definition of protocols, and this is important for two sets of reasons:

1. Good practice considerations
- The guidelines constitute a "national template" for Local Guideline Development
- They represent a serious attempt to bring the evidence base into practice
- They attempt to standardise practice
- They attempt to spell out the responsibilities of different groups of doctors
- They reflect a shift away from old style referral patterns and primary/secondary care divides
- They attempt to bring more doctors into the field and to ensure fewer variations within the field – the guidelines represent an essential stage that has to be reached before this can happen.
- They help to bring drug misuse treatment into the mainstream, which is where it needs to be – but it may mean that those of us already in the field may have to reconsider our practice.

2. Legal Considerations

The guidelines have no defined legal position but:
- They represent a consensus view of good clinical practice.
- They represent a consensus view of good clinical practice and doctors operating in this field can expect to be judged against this reference point. This can of course be our protection, as clinical practice falling within the recommendations of the guidelines can be defended in these terms, but even more importantly the guidelines offer protection for the public against practice which is deficient.

The government 10-year strategy, "Tackling Drugs to Build a Better Britain" (4) states that clinical services and in particular prescription of substitute medication should be in line with the forthcoming clinical guidelines. This means that we need to be able to defend why we deviate from the guidelines if we do.

References

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The 4th National Conference
Management of Drugs Users in General Practice,
'' A Time of Change - Has Anything Changed?'

RCGP, HIV Working Party

The programme for the 4th National Conference on 'Managing Drug Users in General Practice' held on April 23rd 1999, in London was as varied and interesting as one has come to expect from this now annual event.

Entitled 'A time of change - has anything changed? ', the day generated many questions and some answers. The main platform was shared by GPs, service users, representatives of the UK Anti-Drugs campaign and the Department of Health, pharmacists and drug workers. Participants could choose from such diverse workshops as chasing the dragon, alternative therapies, hepatitis C, dual diagnosis, anabolic steroid use, shared care, benzodiazepine prescribing, training in primary care and using significant others in treatment. It 's clear that there is a great deal happening at national and local level. What isn't yet clear is how much change will be achieved, and how welcome some of these changes will be to doctors and drug users.

Given the timely publication, in the week before the conference, of the new Departments of Health Guidelines on clinical management of drug misuse and dependence, these were keenly discussed. The conference generally welcomed them, particularly the recognition that it is the responsibility of all doctors to treat drug users. However, concerns were expressed about some recommendations, including the failure to fully identify the effectiveness of treatments other than oral methadone. Clearly there needs to be ongoing discussion of the guidelines in the local arena and further exploration of the appropriateness and feasibility of recommendations such as the supervised consumption of daily methadone doses in community pharmacies, and establishing a role for the new kind of GP described as a 'specialised generalist'....

It was good news to hear that DoH funding has now been made available to set up a support network for primary care professionals working with drug users. The initiative and development work for this project arose from a previous conference so the achievement of the network was especially welcomed. It will be set up under the auspices of the Substance Misuse Advisory Service, and should be a valuable resource to help share experience, promote effective practice and encourage the establishment of shared care schemes to support GPs who look after drug using patients.

We're familiar with 'new Labour', now comes the 'new BMA' - in this case the British Methadone Alliance which had a prominent presence at the conference. This new organisation has been set up to support people receiving prescribed drugs for treatment of their dependency and to ensure they have an authoritative voice which is heard in debates about prescribing policy and wider strategy issues. Encouraging public participation in health care decision making and wishing health services to be responsive to the needs of users is definitely flavour of the year with this government. The new BMA offers a challenge to us all - can we as professionals really listen to the people that our services are for, and change?

As in previous years, this conference was bulging at the seams, with many disappointed applicants unable to get a place. And as usual there simply wasn't enough time in the day just to talk to other delegates and share ideas and experiences in an informal way. Next year's conference will be in Leeds. Perhaps it needs to expand into a bigger affair over two days - but book early anyway to avoid disappointment!

Contact numbers:

For the GP network - Substance Misuse Advisory Service 0171 881 9255
For the British Methadone Alliance 0181 374 2443

Dr Berry Beaumont, General Practitioner, conference organising committee

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Starting of the GP Network

The network is now ready to begin. After much competition the position of Network Co-ordinator has been filled. Jean-Claude Barjolin will begin work with SMAS at the beginning of August. Many of you will know J-C from this newsletter and the conferences. He has a wealth of experience in the area of primary care and substance misuse and I am sure he will be a real asset to the network. I am really looking forward to working with him! He will soon be contacting you to look at how the network can help you and possible areas of joint work. Any suggestions give him a ring on the number above.

We hope that the next newsletter will be revamped and extended to include more articles, information, points of view and letters -so get writing! Plus any ideas on what you would like in future newsletters? What do you think about the guidelines? Do you agree with Jenny's analysis or not? How did you feel about the vicious attack on drug users at both the LMC and BMA conference? *Chris Ford (ed.)*

Newsletter edited by Chris Ford, Brian Whitehead and Jean-Claude Barjolin. If you have contributions or suggestions please let us know. Or if you would like to join the mailing list for this newsletter, please contact: SMMGP Newsletter, Brent & Harrow Health Authority, Harrovian Business Village, Bessborough Road, Harrow HA1 3EX P:0181.966.1109 Fax:0181.426.8646